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MENINGOCELE TREATED BY PLASTIC OPERATION.

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If guided by certain text-books, the surgical student might be led to think that the excision of a meningocele, either connected with the spine or the skull, is an operation so heroic as to be unjustifiable.

This is evidently a survival of the preantiseptic era and with certain reservations may be disregarded.

In a paper read before the International Congress at Rome and illustrated by a series of 20 cases, I stated my views very fully with regard to spina bifida, many of the cases related being examples of meningocele.

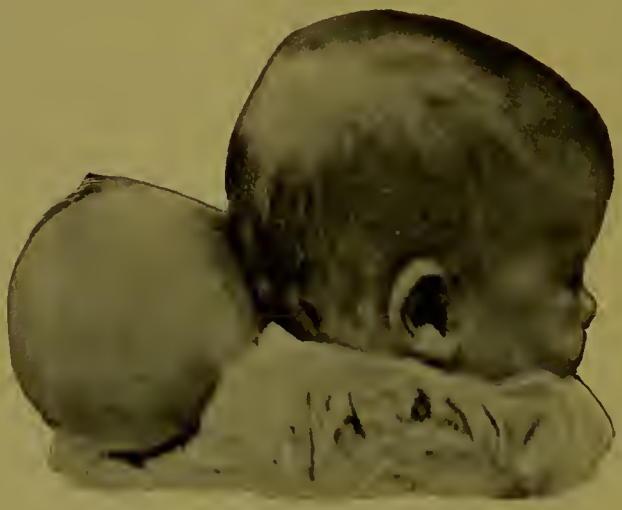
The only really serious difficulty in operating on a cranial meningocele is that occasionally a portion of the nerve-centres may be contained in the sac, but this may usually be diagnosed by careful palpation with or without a preliminary aspiration of the sac. At times this complication may be difficult to determine, as the cerebellar protrusion may be so small and so soft as to be with difficulty felt. This uncertainty need not, however, prevent an exploratory operation, for if after reflecting a flap of the integuments near the base of the tumor a small incision just large enough to admit the finger be made into the meningeal sac, this can be effectually closed if it be deemed unwise to proceed further with the operation. In a case of this kind I found the cerebellum lying in the sac and attached by a long pedicle. Not feeling justified in performing a physiological experiment by removing the cerebellum, I sutured the small incision by separate meningeal and skin sutures, and the child recovered, to be again brought by the mother three months later with a request that I would remove the tumor at all risks; which, however, after a consultation with my colleagues, I declined to do. In simple meningocele there is usually a distinct neck to the meningeal sac, which can be ligatured after the integuments have been dissected off; the skin-flaps can then be sutured separately, so that the ligatured neck of the sac lies out of the line of the superficial sutures.

In the cases in which I have operated primary union has been the rule, and recovery from operation has not only been satisfactory, but the after-development of the children has not been impaired.

The following case is a good example, and the illustration shows the size of the tumor dealt with:

N. H., aged six months, in good general health and otherwise well developed, was brought to the General Infirmary at Leeds with the occipital tumor as shown in Fig. 1; the history being that at birth the swelling was only the size of an egg, and that it had increased rapidly, especially during the previous two or three weeks.

FIG. 1.



At first the swelling was pale on the surface, but of late it had become red and inflamed. On admission the tumor was translucent at the fundus, and the coverings were inflamed over an area of several inches, though the redness stopped short of the base of the swelling, which was very tense, the tension being increased when the child cried.

From the rapid increase in size, the attenuation of the coverings, and the inflammation of the fundus, it was quite manifest that unless curative measures could be adopted the end must come within a short time. Permission for operation was therefore asked and readily granted. The tumor was shaved and asepticized by 1 in 40 carbolic dressing, applied for a few hours before operating.

September 27th. A mixture of chloroform and ether was administered, and a curved incision made through the skin on the left side of the base of the tumor so as to form a flap; a small exploratory incision was then made through the meningeal wall of the sac, when fifteen ounces of clear cerebro-spinal fluid escaped; the finger was inserted, and it was found that the opening into the skull was quite free and about $\frac{1}{3}$ inch in diameter; the skin-incision was therefore continued round the base and the meningeal pedicle freed, the latter was ligatured with a fine silk suture, and the tumor was removed by an incision just beyond the ligature, which was then cut short. The integumental flap was then brought over the pedicle and fixed *in situ* by silkworm-gut stitches.

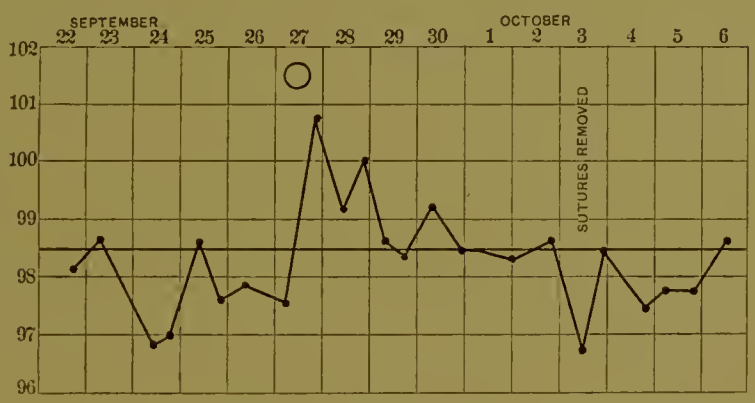
The after-progress was perfectly satisfactory, as shown by the tem-

perature-chart. The child took the breast soon after the operation, and apparently experienced no discomfort. The sutures were removed

FIG. 2.

on the sixth day, when the wound was found to be healed, and the patient was discharged cured on the ninth day. When heard of some time afterward it was well and thriving.

FIG. 3.



This operation, I feel sure from ample experience, is one which can be recommended in a class of cases otherwise hopeless; but unless the operator is prepared to take every pains, both in the details of the operation and in the observance of antiseptic precautions, the older rule of non-interference had better be observed.